Arizona Department of Insurance

FRAUD UNIT
TEL: 602-912-8418
FAX: 602-912-8419

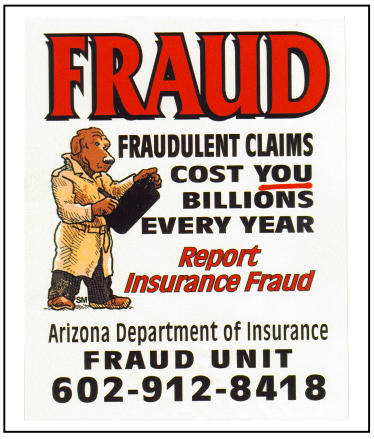
What is insurance fraud?

Insurance fraud is a crime — a class six felony that can mean 10 years in jail and a maximum fine of $150,000.

Person(s) who commits either of the following "with the intent to injure, defraud, or deceive an insurance company," is guilty of a felony. The most common types of insurance fraud include claim fraud, premium fraud and vender (or provider) fraud. Incomplete or inaccurate information on a claim form or application does not necessarily represent insurance fraud. For insurance fraud to exist, four key elements need to be present:

1. **INTENT TO DEFRAUD**: The person(s) must intentionally and deliberately deceive the insurer(s).
2. **KNOWLEDGE**: The person(s) must have knowledge that what they are doing is wrong, or is a false statement of fact.
3. **MISREPRESENTATION**: The person(s) creates or assists in making a false impression that leads the insurer to pay a claim.
4. **RELIANCE**: The insurer would not have paid the claim but for the misrepresentation.

Does insurance fraud affect me?



Insurance fraud is perceived as a victimless crime; however the estimated losses to this crime are more than $100 **Billion** every year. Ten percent (10%) of all claims (property & casualty, health, life, workers' compensation) are assessed as fraudulent. Although there are no comprehensive figures indicated dollar losses in Arizona are being quantified, 10% of all health care and property & casualty claims no doubt comes to a staggering total.

According to the Insurance Research Council, 30% of all bodily injury Arizona appear to be fraudulent or contain injury exaggeration. In Phoenix, that figures goes up to 36%.

The losses to fraudulent auto insurance claims in Arizona cost the policyholders an average of $167 to $200 in higher annual premiums.

The higher premiums affect not only individual policyholders, but also commercial businesses that will in turn increase their costs to their customers. All of which means more money out of the consumers' pockets.

What does the Fraud Unit do about it?

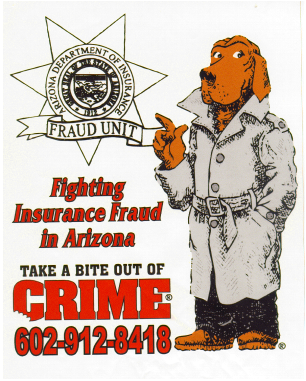
The Fraud Unit has the ability and resources to devote all its time to insurance fraud; whereas other law enforcement agencies are targeting their attention to violent crimes.

This Unit began in the fiscal year 1994 after the Governor signed a bill into law to provide for the investigation of criminal fraud by members of the Arizona Department of Insurance (ADOI). Fraud Unit. ***Arizona fraud statutes*** make it unlawful to make or assist in the making of a fraudulent insurance claim against any licensed insurer in Arizona.

Through the ***investigation process*** of fraudulent claims and practices and the education of the public (through seminars)the Fraud Unit strives to reduce this increasingly costly problem. We are not alone in this fight. The Attorney General's and County Attorney's Investigations units, insurance companies, local law enforcement as well as the National Insurance Crime Bureau (NICB) work hand-in-hand with the Fraud Unit to combat insurance crimes.

What should I do if I believe someone has filed a fraudulent claim??

If you believe a fraudulent claim has been made, you may file a report with the Fraud Unit with as many details as possible: the suspect's name, date of birth, Social Security number, insurance company, type of claim the person is filing, etc.. Insurance companies who believe a fraudulent claim is being made are required to send the Fraud Unit (on a prescribed form available at the Arizona Department of Insurance) information relative to the claim and any other information the Fraud Unit may require. There is no mandatory format for consumers to use.



You can file a report with the Fraud Unit by calling 602-912-8418, faxing us complete details at 602-912-8419 or mailing the information to ADOI - Fraud Unit, 2910 N. 44th St., #210, Phoenix, AZ 85018.

The Fraud Unit's Investigation Process

The investigative process by the fraud unit includes the following steps:

- Upon receiving a referral from an insurance company or an individual, the Fraud Unit staff first evaluates it to determine whether it merits a full investigation. If a referral is judged to warrant further examination, it is assigned to an investigator.
- Once a case is opened, the Fraud Unit will not comment on it, nor does it comment on any ongoing investigation.
- Investigations recommended for criminal prosecution are referred to the Attorney General's Office.
- All referrals, including those that are determined not to merit a full investigation, are entered into the Fraud Unit's database. Subsequent referrals may then be compared to the information in the database for similar claims or patterns.

An Insurer Is Required to Submit Fraudulent Claims to the Fraud Unit.

The insurance company's responsibilities in submitting suspected fraudulent claims to the Fraud Unit

Arizona law requires that any insurer who suspects a claim is fraudulent is required to make a fraud referral to the Arizona Department of Insurance Fraud Unit in a form prescribed by the Director of Insurance. The specific statutes are listed below:

Arizona Revised Statute § 20-466.F states:

> An insurer that believes a fraudulent claim has been or is being made shall send to the director, on a form prescribed by the director, information relative to the claim including the identity of parties claiming loss or damage as a result of an accident and any other information the fraud unit may require. The director shall review the report and determine if further investigation is necessary, the director may conduct an independent investigation to determine if fraud, deceit or intentional misrepresentation in the submission of the claim exists. If the director is satisfied

that fraud, deceit or intentional misrepresentation of any kind has been committed in the submission of a claim, the director may report the violations of the law to the reporting insurer, to the appropriate licensing agency as defined in Section 20-466.04 and to the appropriate county attorney or the attorney general for prosecution

Arizona Revised Statute § 20-466.H states:

A person, or an officer, employee or agent of the person acting within the scope of employment or agency of that officer, employee or agent, who in good faith files a report or provides other information to the fraud unit pursuant to this section is not subject to civil or criminal liability for reporting that information to the fraud unit

Two methods of referring claims to the Fraud Unit

1. Complete the Fraud Referral Form and a) mail it to the address shown above, or b) fax the form to 602-912-8419.

2. If you are a member of the National Insurance Crime Bureau (NICB) you may have the referrals you submit to them copied to the Arizona Department of Insurance Fraud Unit. NICB offers insurers the option of sending a copy of their referrals to the appropriate State Department of Insurance. Simply indicate in the box provided that you would like to have your referral copied to Arizona Department of Insurance Fraud Unit.

Notice of Penalty for false or fraudulent claim forms

Insurers are required to include substantially the following statement on their claim forms, ***in at least 12 point type***:

> For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties."
>
> *A.R.S. § 20-466.03*

Contacting the Fraud Unit about your referrals

Our investigators will contact the person indicated on your referrals about your claims to obtain more information, copy of claims files, etc. When the investigator has completed the investigation you will receive a letter from us advising you of the disposition of the case. Of course any time during this process you are invited to call our office with any questions or concerns about your referrals or the referral process.

Your referrals are vital in the combat against insurance fraud

The referrals submitted to us by the insurance industry have assisted the Fraud Unit in fighting insurance fraud. With your help and the help of the prosecutors, numerous suspects have been indicted and convicted. In addition, the total amount of restitution ordered is growing rapidly.

With your continuing support, especially by making referrals to the Fraud Unit, we can make bigger and broader strikes against those who commit insurance fraud in Arizona.

Arizona Fraud Statutes (Enacted April 29, 1997)

ARIZONA REVISED STATUTES:

20-441. Purpose of article; definition

A. Among the purposes of this article is the regulation of trade practices in the business of insurance in accordance with the intent of Congress as expressed in the act of Congress of March 9, 1945, 59 Stat. 33, by defining, or providing for the determination of, all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.

B. For the purposes of this article, "insurance company" or "insurer" means any stock, mutual, reciprocal, benefit, benefit stock or title insurer, or fraternal benefit society, health care services organization, or hospital, medical, dental and optometric service corporation, or prepaid dental plan organization, mechanical reimbursement reinsurer, prepaid legal plan, Lloyd's association, service company as defined in this title or any other entity under this title.

20-463. Fraud; injunction; penalties; restitution; definitions.

A. It is a fraudulent practice and unlawful for a person to knowingly:

1. Present, cause to be presented or prepare with the knowledge or belief that it will be presented an oral or written statement, including computer generated documents, to or by an insurer, reinsurer, purported insurer or reinsurer, broker or agent of an insurer, reinsurer or broker that contains untrue statements of material fact or that fails to state any material fact with respect to any of the following:

(a) An application for the issuance or renewal of an insurance policy.
(b) The rating of an insurance policy.
(c) A claim for payment or benefit pursuant to an insurance policy.
(d) Premiums paid on any insurance policy.
(e) Payments made pursuant to the terms of any insurance policy.
(f) An application for a certificate of authority.
(g) The financial condition of an insurer, reinsurer or purported insurer or reinsurer.

(h) The acquisition of an insurer or reinsurer or the concealing of any information concerning any fact material to the acquisition.

2. Solicit or accept new or renewal insurance risks by or for any insolvent insurer, reinsurer or any other entity licensed to transact insurance business in this state.

3. Conceal or attempt to conceal from the department or remove or attempt to remove from the home office, place of safekeeping or other place of business of any insurer, reinsurer or other entity licensed to transact insurance business in this state part or all of the assets or records of the assets, transactions and affairs.

4. Divert or attempt to conspire to divert the monies of an insurer, reinsurer, entity licensed to transact insurance business in this state or other person in connection with:

(a) The transaction of insurance or reinsurance.

(b) The conduct of business activities by any insurer, reinsurer or other entity licensed to transact insurance business in this state.

(c) The formation, acquisition or dissolution of any insurer, reinsurer or other entity licensed to transact insurance business in this state.

5. Assist, abet, solicit or conspire with another person to violate paragraph 1 of this subsection.

6. Employ, use or act as a runner, capper or steerer for the purposes of violating paragraph 1 of this subsection.

B. A person who acts without malice, fraudulent intent or bad faith is not subject to liability for filing reports or furnishing orally or in writing other information concerning suspected, anticipated or completed fraudulent insurance acts if the reports or information is provided to or received from:

1. The director or the department.

2. Law enforcement officials and their agents and employees.

3. The national association of insurance commissioners, other state insurance departments, a federal or state agency or bureau established to detect and prevent fraudulent insurance acts, and the agency's or bureau's agents, employees or designees, or an organization established by insurers to assist in the detection and prevention of fraudulent insurance acts, and the organization's agents, employees or designees.

C. A person, or an officer, employee or agent of the person acting within the scope of employment or agency of that officer, employee or agent, identified under subsection B, paragraph 1, 2, or 3 when performing authorized activities without malice, fraudulent intent or bad faith is not subject to civil liability for libel, slander or another relevant tort. No civil cause of action may be brought against the person or entity.

D. A person or entity under subsection B or C is entitled to an award of attorney fees and costs if the person or entity is a prevailing party in a civil cause of action for libel, slander or other relevant tort and the action is not substantially justified. For purposes of this subsection, "substantially justified" mans a proceeding that has a reasonable basis in law or fact at the time that it is initiated.

E. Nothing in this section limits any common law right of the person or entity.

F. Nothing in this section is intended to prohibit contact or communication with clients or patients for any lawful purpose, including communication by and between

insurers, the insurers' policyholders and claimants under policies issued to the insurers' policyholders regarding the investigation or settlement of any claim.

G. For the purposes of this section:

1. "Runner," "Capper" or "Steerer" means a person who procures clients at the direction of, or in cooperation with a person who intends to perform or obtain services or benefits under a contract of insurance who intends to assert a claim against an insured.

2. "Statement" includes any notice, proof of injury, bill for services, payment for services, hospital or doctor records, X-rays test reports, medical or legal expenses, or other evidence of loss or injury, or other expense or payment.

20-466. <u>Fraud unit; power; duty of insurers</u>.

A. A fraud unit is established in the department of insurance.

B. The fraud unit shall work in conjunction with the department of public safety.

C. The director may investigate any act or practice of fraud prohibited by section 20-466.01 and any other act or practice of fraud against an insurer or entity licensed under this title. The director shall administer the fraud unit.

D. The director may request the submission of papers, documents, reports or other evidence relative to an investigation under this section. The director may issue subpoenas and take other actions pursuant to section 20-160. The materials are privileged and confidential until the director completes the investigation. The materials are not subject to discovery or subpoena until opened for public inspection by the fraud unit unless the director consents or, after notice and a hearing, a court determines that the director would not be unduly burdened by compliance with the subpoena.

E. If materials the director seeks to obtain by request are located outside this state, the person requested to provide the materials shall arrange for the fraud unit or a representative, including an official of the state in which the materials are located, to examine the materials where the materials are located. The director may respond to similar requests from other states.

F. An insurer that believes a fraudulent claim has been or is being made shall send to the director, on a form prescribed by the director, information relative to the claim including the identity of parties claiming loss or damage as a result of an accident and any other information the fraud unit may require. The director shall review the report and determine if further investigation is necessary, the director may conduct an independent investigation to determine if fraud, deceit or intentional misrepresentation in the submission of the claim exists. If the director is satisfied that fraud, deceit or intentional misrepresentation of any kind has been committed in the submission of a claim, the director may report the violations of the law to the reporting insurer, to the appropriate licensing agency as defined in Section 20-466.04 and to the appropriate county attorney or the attorney general for prosecution.

G. Beginning on July 1, 1997, the director shall annually assess each insurer, as defined in section 20-441, subsection B authorized to transact business in this state up to seven hundred dollars for the administration and operation of the fraud unit and the prosecution of fraud pursuant to this section. Monies collected shall be deposited in the state general fund. The director shall annually revise the fee in such a manner that the

revenue derived from the fees equals at least ninety-five percent but not more than one hundred ten percent of the appropriated budget of the fraud unit for the prior fiscal year.

H. A person, or an officer, employee or agent of the person acting within the scope of employment or agency of that officer, employee or agent, who in good faith files a report or provides other information to the fraud unit pursuant to this section is not subject to civil or criminal liability for reporting that information to the fraud unit.

20-466.01 Fraud; classification

A person who violates section 20-463 with the intent to injure, defraud or deceive an insurer is guilty of a class 6 felony.

20-466.02. Injunction; restitution; civil penalties; costs

A. On request by the director, the attorney general may seek and obtain in an action in the superior court an injunction that prohibits a person from engaging in practices or doing any acts that violate section 20-463 or 23-1028. The court may enter any order or judgment that is necessary to:

1. Prevent any act or practice that is unlawful under section 20-463 and 20-1028.

2. Return any monies, interest or real or personal property that was acquired by an act or practice that is unlawful under section 20-463 or 20-1028.

B. An order of restitution may also include expenses incurred and paid by an insurer in connection with any medical evaluation or treatment services.

C. If the court finds that a person has violated section 20-463 or 23-1028, the attorney general on petition or complaint to the court may recover from that person on behalf of the state a civil penalty of not more than five thousand dollars for each violation.

D. In any action pursuant to this section, the court may award the attorney general costs including reasonable attorney fees and investigative costs for the services rendered.

20-466.03. Notice of penalty for false or fraudulent claims; claim forms.

The forms provided by an insurer to an insured or any other person for filing a notice or making a claim in connection with a policy or contract issued by the insurer shall include in substance the following statement in at least twelve point type:

"For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties."

20-466.04. Referrals to other licensing agencies; definition.

A. The director shall forward to the appropriate licensing agency the name of any person who is convicted of, enjoined from or penalized for violating section 20-463 or 20-1028. The director shall include any information the director believes is material to the case.

B. A person whose name is forwarded pursuant to subsection A of this section has no cause of action against the director and the department's employees and agents pursuant to any administrative appeal or judicial review.

C. For the purposes of this section, "licensing agency" means any state board, commission, department or agency that issues any occupational or professional license, permit or registration and the state bar of Arizona.

Sec. 6. Section 23-1028

23-1028 False statements or representations to obtain compensation; forfeiture; classification; definition.

A. If in order to obtain any compensation, benefit or payment under the provisions of this chapter, either for himself or for another, any person knowingly makes a false statement or representation, such person is guilty of a class 6 felony, and, if the person is a claimant for compensation, benefit or payment, he shall in additional forfeit all right to such compensation, benefit or payment after conviction of the offense.

B. Notwithstanding section 13-801, a sentence to pay a fine for a violation of this section by a claimant or co-employee shall be a sentence to pay a amount fixed by the court of not more than fifty thousand dollars.

C. Any person who commits a violation under this section is also subject tot he penalties prescribed in sections 20-466.02 and 20-466.04.

D. For the purposes of this section, "statement" includes any notice, proof of injury, bill for services, payment for services, hospital or doctor records, X-rays, test reports, medical or legal expenses, or other evidence of loss or injury, or other expense or payment.

Sec. 7. Appropriation.

In addition to any other appropriation provided by law, for fiscal years 1997--19983 and 1998-1999, the department of insurance is appropriated the amount of the increased assessment provided in section 20-466, Arizona Revised Statutes, as amended by this act, or $320,000, whichever is less, for the purposes provided in this act. In fiscal years 1997-1998 and 1998-1999, at least one hundred twenty thousand dollars per year shall be used only for the prosecution of fraud pursuant to this section.

Sec. 8. Requirements for enactment

Pursuant to article IX, section 22, Constitution of Arizona, this act is effective only on the affirmative vote of at least two-thirds of the members of each house of the legislature and is effective immediately on the signature of the governor or, if the governor vetoes this act, on the subsequent affirmative vote of at least three-fourths of the members of each house of the Legislature.

Approved by the Governor April 29, 1997.

Filed in the Office of the Secretary of State April 30, 1997.

Fraud Referral Form for Submitting Fraudulent Claims

Instructions and Codes
Fraud Referral Form
Fraud Referral Addendum

ADOI

Arizona
Department of Insurance

FRAUD REFERRAL

Page ___ of _____

**** See Instructions on Reverse Side***

2910 N. 44th St., 210
Phoenix, AZ 85018
602-912-8418
FAX: 602-912-8419

☐ SUBMITTED TO INITIATE INVESTIGATION ☐ SUBMITTED FOR INFORMATION ONLY

DATE OF PREPARATION ____|____|____ INSURANCE CO_____NAIC #:_____

INS CO ADDRESS: _____CITY:_____ST:_____ZIP:_____

CONTACT PERSON: _____PHONE: (_____)_____

POLICY #: _____ CLAIM #: _____ DATE OF LOSS: _____|_____|_____

REASON FOR SUSPICION CODES*: | | | | | | | | | | |

HAS LAW ENFORCEMENT RECEIVED THIS INFORMATION? ☐ YES ☐ NO IF YES, SPECIFY AGENCY BELOW

LAW ENFORCEMENT AGENCY: _____

LAW ENFORCEMENT CONTACT: _____PHONE: (____)_____

NOTIFIED NICB? YES ☐ NO ☐ WHY DO YOU SUSPECT FRAUD (REASON FOR REFERRAL)?:_____

_____

_____

_____

LOCATION OF LOSS/ADDRESS: _____CITY:_____ST_____ZIP:_____

POLICY TYPE*:_____ LOSS TYPE*:_____ EST. CLAIM VALUE: _____ PAID? ☐ YES ☐ NO

**** See Instructions on Reverse Side***

COMPLETE THIS SECTION FOR WORKER'S COMP OR HEALTH CARE PROVIDER REFERRAL

HEALTH CARE PROVIDER: _____TIN:_____

ADDRESS: _____PHONE: (____)_____

IS HEALTH CARE PROVIDER SUBJECT OF THIS REFERRAL?: ☐ YES ☐ NO

ANY PREVIOUS WORKER'S COMP/OR/OTHER CLAIMS?: ☐ YES ☐ NO

ANY OUTSIDE INVESTIGATION OR SURVEILLANCE CONDUCTED? ☐ YES ☐ NO VIDEO? ☐ YES ☐ NO

OUTSIDE INVESTIGATOR: _____ PHONE: (_____)_____

CLAIMANT AND OTHER ROLE INFORMATION

ROLE*: _____ NAME (FIRST, MI, LAST):_____

BUSINESS/DBA/ALIAS: _____PHONE (_____)_____

ADDRESS:_____CITY: _____ST:_____ZIP:_____

DOB: ___|____|___ SSN: _____ TIN(S):_____

OCCUPATION: _____ DRIVERS LIC #:_____DRIV.LIC ST_____

VIN: _____ VEH. YR: _____ MAKE *:_____ MODEL *:_____ STYLE*:_____

LIC. PLATE #:_____ LIC. YR: _____ LIC ST:_____ LIC TYPE*:_____

REPORTED INJURIES, DISEASE, ILLNESS OR CONDITION: _____

_____

**** See Instructions on Reverse Side***

ADOI USE ONLY

CONTROL NUMBER | | | | | | |

ADOI REVIEWER: _____ DATE: ____|____|_____

CASE ASSIGNED TO: _____ DATE: ____|____|_____

REFERRAL DISPOSITION CODE | |

PLEASE USE ADDENDUM FORMS FOR ADDITIONAL ROLE INFORMATION

ADOI

Arizona
Department of Insurance

FRAUD REFERRAL ADDENDUM

Page ___ of _____

(ADOI USE ONLY)

CONTROL NUMBER

POLICY #: ______________________________ CLAIM #: ____________________ DATE OF LOSS:___|____|____

ROLE*: ______ NAME (FIRST, MI, LAST):____

BUSINESS/DBA/ALIAS: ______________________________________PHONE (_____)__________________

ADDRESS:______________________________________CITY: _____________________ST:_____ZIP:_____________

DOB: ___|____|___ SSN: ____________________________ TIN(S):_______________________________________

OCCUPATION: ___________________________ DRIVERS LIC #:___________________________DRIV.LIC ST_______

VIN: ________________________ | VEH. YR: ______ | MAKE *:_________ | MODEL *:___________ | STYLE*:________

LIC. PLATE #:______________________________ LIC. YR: __________ LIC ST:__________ LIC TYPE*:_______________

REPORTED INJURIES, DISEASE, ILLNESS OR CONDITION: ____

____

ROLE*: ______ NAME (FIRST, MI, LAST):____

BUSINESS/DBA/ALIAS: ______________________________________PHONE (_____)__________________

ADDRESS:______________________________________CITY: _____________________ST:_____ZIP:_____________

DOB: ___|____|___ SSN: ____________________________ TIN(S):_______________________________________

OCCUPATION: ___________________________ DRIVERS LIC #:___________________________DRIV.LIC ST_______

VIN: ________________________ | VEH. YR: ______ | MAKE *:_________ | MODEL *:___________ | STYLE*:________

LIC. PLATE #:______________________________ LIC. YR: __________ LIC ST:__________ LIC TYPE*:_______________

REPORTED INJURIES, DISEASE, ILLNESS OR CONDITION: ____

____

ROLE*: ______ NAME (FIRST, MI, LAST):____

BUSINESS/DBA/ALIAS: ______________________________________PHONE (_____)__________________

ADDRESS:______________________________________CITY: _____________________ST:_____ZIP:_____________

DOB: ___|____|___ SSN: ____________________________ TIN(S):_______________________________________

OCCUPATION: ___________________________ DRIVERS LIC #:___________________________DRIV.LIC ST_______

VIN: ________________________ | VEH. YR: ______ | MAKE *:_________ | MODEL *:___________ | STYLE*:________

LIC. PLATE #:______________________________ LIC. YR: __________ LIC ST:__________ LIC TYPE*:_______________

REPORTED INJURIES, DISEASE, ILLNESS OR CONDITION: ____

____

ROLE*: ______ NAME (FIRST, MI, LAST):____

BUSINESS/DBA/ALIAS: ______________________________________PHONE (_____)__________________

ADDRESS:______________________________________CITY: _____________________ST:_____ZIP:_____________

DOB: ___|____|___ SSN: ____________________________ TIN(S):_______________________________________

OCCUPATION: ___________________________ DRIVERS LIC #:___________________________DRIV.LIC ST_______

VIN: ________________________ | VEH. YR: ______ | MAKE *:_________ | MODEL *:___________ | STYLE*:________

LIC. PLATE #:______________________________ LIC. YR: __________ LIC ST:__________ LIC TYPE*:_______________

REPORTED INJURIES, DISEASE, ILLNESS OR CONDITION: ____

____

INSTRUCTIONS

To expedite the referral process please fill out all necessary items as completely as possible.

Use a separate form for each claim number and mail or fax to the address/phone listed below.

Use as many forms as necessary for additional insured, claimants, doctors, attorneys, etc. And repeat the claim number on every form.

Staple all related forms together.

MAIL TO: ADOI - FRAUD UNIT
2910 N. 44TH ST., #210
PHOENIX, AZ 85018

FAX TO: 602-912-8419

REASON FOR SUSPICION CODES

Code	Description
AM	Application Misrepresentation
AR	Arson
CI	Claim Investigation Resulted In Denial/Reduction/ Withdrawal
FL	Fictitious Loss
IF	Inflated Loss
IS	Illegal Solicitation (chasers/ Cappers)
KB	Kick Backs/Bribery
MC	Multiple Claims
ML	Medical Provider/Lawyer Relationship
MP	Medical Provider
MS	Misappropriated Vehicle Salvage
QB	Questionable Billing
RO	Ring/Organized Activity (excl. veh.)
RW	Returned to Work
SA	Staged/Caused Accident
SR	Specials/Receipts (Altered/ Questionable/Duplicate)
UR	Unperformed Repairs
VA	Vehicle Arson
VF	Vehicle
VR	Vehicle Ring Activity
VT	Vehicle Theft
WC	Work Comp Claimant
WP	Work Comp Premium
FE	Fictitious Employee/ Dependent
FG	Forgery
DM	Diversion/Misappropriation of Funds
OT	Other

LICENSE TYPE CODES

Code	Description
PC	Passenger Car
TK	Truck
TL	Trailer
MC	Motorcycle
CO	Construction Equipment
BU	Bus
FM	Farm
IP	International Plate
IT	In Transit
TR	Truck/Trailer
ZZ	All Others (snowmobiles, ATVs, etc.)

POLICY TYPE CODES

Code	Description
PAUT	Personal Automobile - General
PPAP	Personal Property - General
PPHO	Personal Property -Homeowners
COMP	Commercial - Multi Peril
CCRM	Commercial Crime
CAUT	Commercial Automobile
CPRP	Commercial Property
WORK	Worker's Compensation
ACHE	Accident/Health/Disability
LIFE	Life
MAME	Major Medical
HHMO	HMO
ACON	Accident Only
PRDG	Prescription Drug
DEVI	Dental/Vision
HCMS	Health Care/Medicare Supp.
CASD	Cancer/Specified Disease
MESH	Medical/Surgical Hospital
OTHR	Other

LOSS TYPE CODES

Code	Description
BIAR	Bodily Injury Auto Related
BISF	Bodily Injury Slip & Fall
BURG	Burglary
CONT	Contractor/RepairFacility (incl. auto & Prop)
DETH	Death
DISB	Disability
FIRE	Fire/Burned (incl. Auto/boat & prop.)
HEAL	Health/Medical (includes life, auto & prop)
LOSS	Loss (not stolen)
OTHR	Other
PHYD	Physical Damage/Collision (incl. Auto & Prop.)
ROBB	Robbery
STRM	Storm/Earthquake/Wind (incl. Auto & prop)
THFT	Theft (NOT including Vehicle/Boat thefts)
TVTH	Total Vehicle Theft Not Recovered
VAND	Vandalism
VHTH	Vehicle/Boat Theft (NOT incl. theft from vehicle/boat)
WATR	Water Damage (including fire sprinklers)
ACBE	Accelerated Benefits
ACDD	Accidental Death /Dismemberment
HOSP	Hospitalization
SMLX	Surgical Care/Medical Care/Lab/X-Ray
NHHC	Nursing Home/Home Health Care
PRES	Prescription

ROLE CODES

Code	Description
CL	Claimant
CI	Both Claimant & Insured
CD	Claimant Driver
CP	Claimant Passenger
EM	Employer
IN	Insured
ID	Insured Driver
IP	Insured Passenger
IE	Insured EmplEnrollee/Dependent
WT	Witness
BS	Body Shop
LW	Lawyer/Other
LR	Paralegal
LO	Law Office
IY	Insurance Employee
IB	Agent/Broker
IO	Insurance Personnel
MD	Medical Doctor (MD)
MC	Chiropractor
MA	Physician's Assistant
MO	Other Doctor
MN	Nurse
MT	Physical Therapist
MS	Dentist
MG	Radiologist
MH	Medical Clinic/Hospital
MZ	Office Administrator
MM	Other Medical Personnel
MX	X-Ray Lab
MR	Laboratory
MY	Medical Provider/Other
OP	Other Professional
NP	Other Non-Professional
BE	Beneficiary
HP	Health Care Provider
MP	Medical Equipment Provider
PH	Pharmacy
CR	Creditor/Debtor
AJ	Adjuster
AP	Appraiser
OT	Other

VEHICLE DATA

Vehicle Make: Ford, Toyota, Chevrolet
Vehicle Model: Escort, Camry, Corvette
Vehicle Style: 4-Dr., Convertible

You can also submit this Referral through National Insurance Crime Bureau (NICB).

If you are a member of NICB you may have the referrals you submit to them copied to the Arizona Department of Insurance Fraud Unit. NICB offers insurers the option of sending a copy of their referrals to the appropriate State Department of Insurance. Simply indicate in the box provided by NICB that you would like to have your referral copied to the Arizona Department of Insurance.